

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3520 6 Film G283 3/24/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

03515

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>QUEENSTOWN</u>			c. LENGTH OF STAY IN TB _____			d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>QUEENSTOWN</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				d. STREET ADDRESS _____			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>HENRY</u> Last <u>COLLIER</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1961</u>						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>AUG. 1 - 1874</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOS. HENRY COLLIER</u>					14. MOTHER'S MAIDEN NAME <u>EMILY PORTER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>MRS. WILBUR SMITH</u>			Address <u>QUEENSTOWN MD.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>Hypertensive Pneumonia</u> DUE TO (b) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) _____					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour _____ o. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>60</u> , to <u>March</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 19</u> , 19 <u>61</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>Irvin J. Hoy</u> M.D.					ADDRESS (Street, city or town, state) <u>Queenstown Md.</u>					
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoy MD</u>					DATE SIGNED <u>3/20/61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>MAR. 22</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>			22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>					ADDRESS <u>Church Hill, Md.</u>					
24a. REC'D BY REGISTRAR DATE <u>MAR 24 '61</u>					24b. REGISTRAR'S SIGNATURE <u>Charles E. Haines</u>					

11. COMMITTEE TO ABOLISH MENTAL HOSPITALS

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3521
CERTIFICATE OF DEATH

Reg. Dist. No. 03516

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Guyther Middle C. Griffin Last				4. DATE OF DEATH Month March Day 1 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17-1903	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William T. Griffin				14. MOTHER'S MAIDEN NAME Nellie Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-16-7032		17. INFORMANT Mrs. Alice Griffin--Church Hill, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Haemiplegia, Secondary to metastatic Ca DUE TO (b) Primary Ca Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 20 min 10 day 4 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 24 , 19 61 , to Feb 27 , 19 61 , that I last saw the deceased alive on Feb 27 , 19 61 , and that death occurred at 9:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. R. Layton M.D.				ADDRESS (Street, city or town, state) 1045 Liberty DATE SIGNED 3-3-61			
PHYSICIAN'S NAME (Type) C. R. Layton				Centreville Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF March 4		22c. NAME OF CEMETERY OR CREMATORY Church Hill		22d. LOCATION (City, town, or county) (State) Church Hill Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane				ADDRESS Church Hill, Md		24a. REC'D BY REGISTRAR MAR 8 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

CERTIFICATE OF DEATH

1921

5-10

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		May 10, 1921		Boston, Mass.	
Cause of Death		Disease		Organ		Nature		Site	
Myocardial Infarction		Coronary Artery Disease		Heart		Narrowing of Arteries		Left Ventricle	
Duration of Illness		Time of Day		Month		Year		Place of Residence	
3 weeks		10:00 AM		May		1921		Boston, Mass.	
Occupation		Education		Marital Status		Previous Illnesses		Signature of Physician	
Clerk		High School		Married		Hypertension		J. H. Smith, M.D.	
Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Burial Officer	
A. B. C.		D. E. F.		G. H. I.		J. K. L.		M. N. O.	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a physician is necessary, it should be signed by the physician and the medical director. Page 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3522 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 1b, Film G284 4/4/61 jwk											
03517											
1. PLACE OF DEATH a. COUNTY Queens Anne				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Church Hill				c. LENGTH OF STAY IN 1b MARYLAND			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Alleghany				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES LUTHER GROSH				4. DATE OF DEATH Month Day Year March 22, 19 61				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX White		6. COLOR OR RACE Male		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/20/1889		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SERVICE STATION				10b. KIND OF BUSINESS OR INDUSTRY MD.				11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES C. GROSH				14. MOTHER'S MAIDEN NAME ALICE COOK				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NONE			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT BEULAH P. GROSH				Address CUMBERLAND MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning. DUE TO (b) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Inhalation of carbon monoxide.							
20c. TIME OF INJURY Month, Day, Year Hour e.m. 3/22/ 19 61 p.m.				20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) trailer			
20f. (City or town) Queens Anne Md.				20g. (County) Queens Anne Md.				20h. (State) Queens Anne Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. William V. Lovitt, Jr., M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED March 23, 1961				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/28/61				22c. NAME OF CEMETERY OR CREMATORY HILLCREST PARK CEM. CUMBERLAND MD.			
22d. LOCATION (City, town, or country) MD.				23. FUNERAL DIRECTOR KIGHT FUNERAL HOME, CUMBERLAND MD							
24a. REC'D BY REGISTRAR MAR 27 '61				24b. REGISTRAR'S SIGNATURE Christina S. Kneass							

1000

PLANTIC TREATMENT OF HEALING

PLANTIC TREATMENT OF HEALING



PLANTIC TREATMENT OF HEALING



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PLANTIC TREATMENT OF HEALING

PLANTIC TREATMENT OF HEALING

PLANTIC TREATMENT OF HEALING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3523

CERTIFICATE OF DEATH

13518

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <u>306 N. COMMERCE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WASHINGTON KENNARD NELSON</u>		4. DATE OF DEATH Month Day Year <u>MARCH 17 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEBRUARY 26-1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FOREMAN STATE ROADS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PERRY'S CORNER MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>THOMAS NELSON</u>	
14. MOTHER'S MAIDEN NAME <u>ELIZABETH E BENTON</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>CORA MAE NELSON, CENTREVILLE MARYLAND</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAR. 13</u> , 19 <u>61</u> , to <u>Mar. 17</u> , 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>MAR. 16</u> , 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John R. Smith, Jr.</u>		22b. DATE SIGNED <u>M.D.</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN R. SMITH, JR., M.D.</u>		22d. ADDRESS <u>CENTREVILLE, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 20, 61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chesapeake</u>		23d. LOCATION (City, town or county) (State) <u>Centreville Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William R. Smith, Jr.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 21 '61</u>	
ADDRESS <u>Centreville Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1223

(M)

(1)

11-21-11

1. The first thing I noticed when I stepped
 out of the plane was the cold. It was a
 sharp contrast to the warm air of the
 plane. I shivered as I walked down the
 stairs. The ground was covered in a thin
 layer of snow. The trees were bare and
 the sky was a pale, overcast grey. I
 took a deep breath and felt the cold air
 fill my lungs. It was a strange feeling,

but it was also refreshing. I had heard
 that the weather in the north was harsh,
 but I didn't realize just how cold it would
 be. The snow was soft underfoot, and the
 trees looked like giant sentinels. I
 walked for a while, trying to get my
 bearings. The air was crisp and clean, a
 far cry from the stuffy atmosphere of the
 plane. I felt a sense of freedom as I
 walked. The cold was a challenge, but it
 was also a reminder of the beauty of the
 world. I had come to a new place, and
 I was going to make the most of it.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3524

03519

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seasonville</u> c. LENGTH OF STAY IN 1b <u>?</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seasonville</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seasonville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIAN AURILLA O'DONNELL</u>				4. DATE OF DEATH Month Day Year <u>MAR 3 1961</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 2 - 1893</u>									
9. AGE (In years last birthday) <u>67</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WHITRESS & HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL CAFETERIA</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Queen Anne's Co. Md</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>FRANK WARNER</u>											
14. MOTHER'S MAIDEN NAME <u>ELLA KIRWIN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>											
16. SOCIAL SECURITY NO. <u>21-38-065A</u>				17. INFORMANT <u>HARRY O'DONNELL</u> Address <u>GRASSVILLE MARYLAND</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>hypertensive arteriosclerotic heart disease</u> DUE TO (c) <u>arteriosclerosis general + cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>essential hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>years</u> INTERVAL BETWEEN ONSET AND DEATH <u>March 3. 61.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from <u>January 19, 1959</u> to <u>March 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 2, 1961</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Theodor Sattelmaier</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 4, 1961</u>									
22c. PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER</u>				22d. ADDRESS <u>Stevensville, Maryland.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 6-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		23d. LOCATION (City, town or county) <u>Stevensville Maryland</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Ernest Banta</u>				ADDRESS <u>Porter Bros Centerville Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 9 '61</u>									
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>											

Received of the Treasurer of the
 the sum of \$100.00

1888

for the sum of \$100.00
 the sum of \$100.00
 the sum of \$100.00

1888

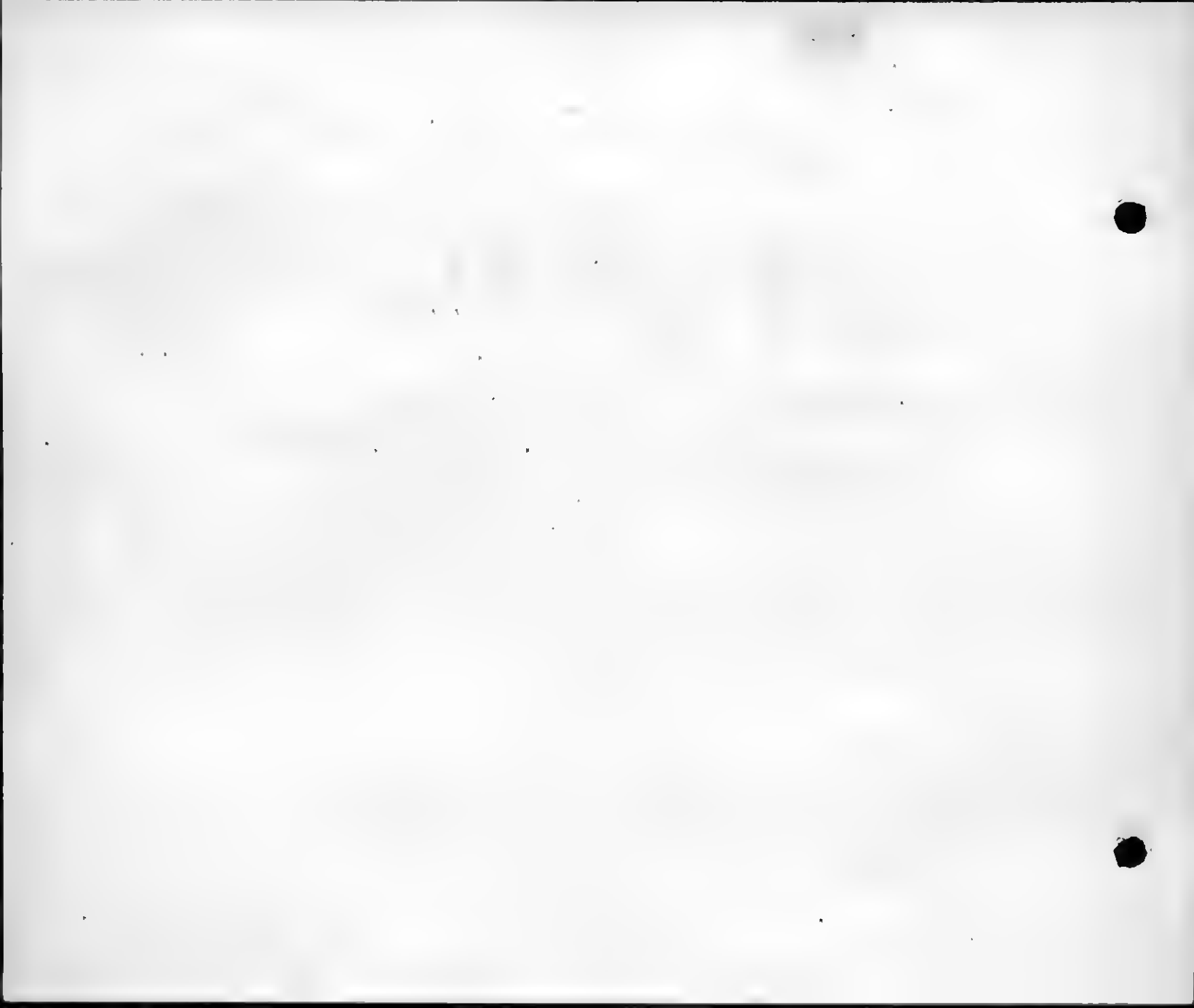
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3525 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 1d, Film G284 4/6/61 1wk
CERTIFICATE OF DEATH

Reg. Dist. No. 03520

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Prices Station, Centreville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private Home				d. STREET ADDRESS 14X-2			
3. NAME OF DECEASED (Type or print) First Alfred Middle N. Last Robinson				4. DATE OF DEATH Month March Day 27 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October, 9, 1882		9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles L. Robinson			
14. MOTHER'S MAIDEN NAME Laura Wilson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Anna Wallace, Box 51, Rural Centreville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of brain DUE TO (c) Atherosclerosis Generalized							INTERVAL BETWEEN ONSET AND DEATH 10 days Yrs Yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 20, 1961 to March 21, 1961 , that I last saw the deceased alive on March 17, 1961 , and that death occurred at 2:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. R. Layton M.D.				ADDRESS (Street, city or town, state) 1045 Liberty St. 3-27-61		DATE SIGNED	
PHYSICIAN'S NAME (Type) C. R. Layton				Centreville Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 30, 1961		22c. NAME OF CEMETERY OR CREMATORY Millington Cemetery		22d. LOCATION (City, town, or county) (State) Millington, Kent Co; Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.				24a. REC'D BY REGISTRAR MAR 30 '61		24b. REGISTRAR'S SIGNATURE Arthur S. House	



3526

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

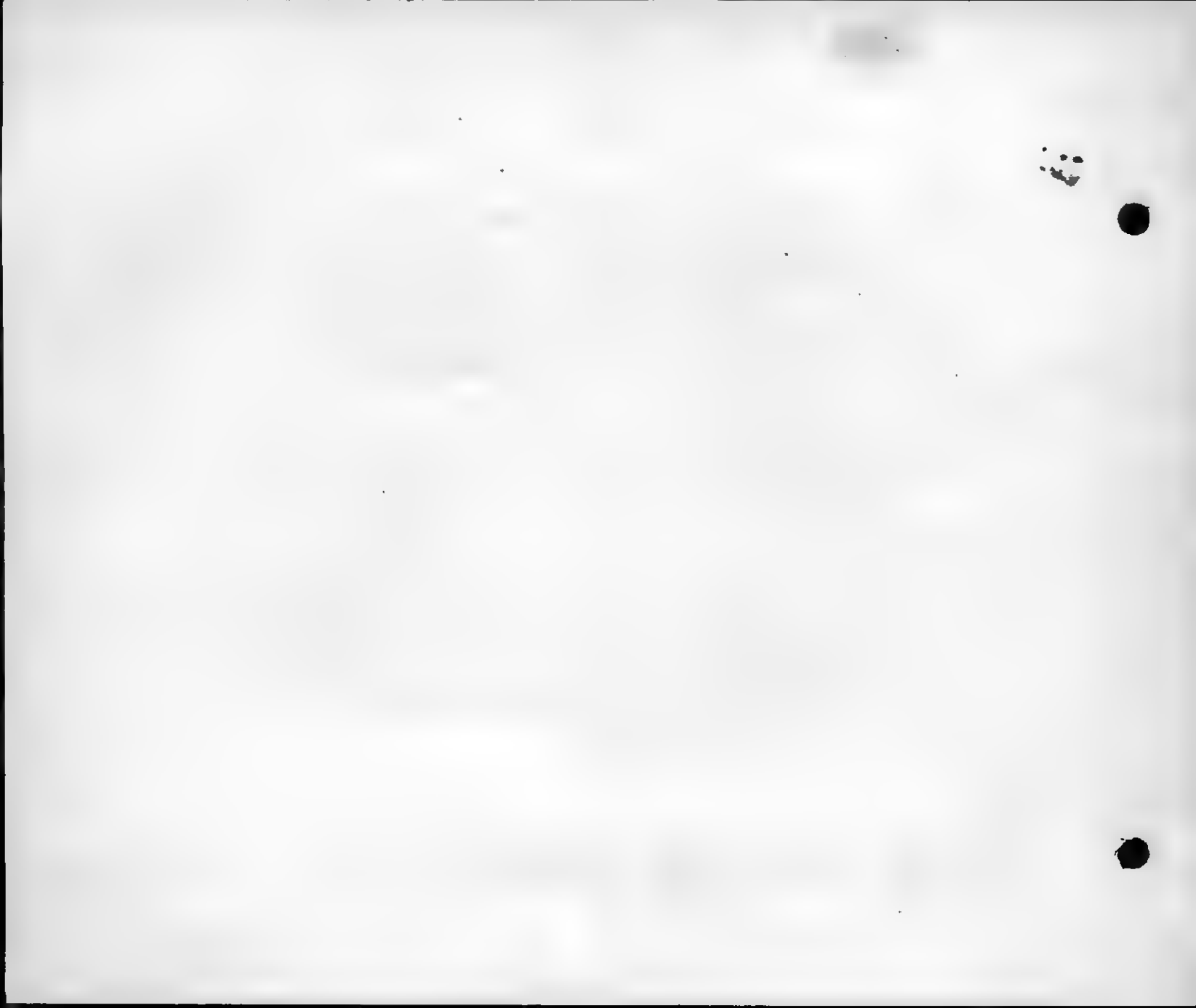
03521

Items 1d, & 25b, Film G284 4/5/61 iwk

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grassville</u>		c. LENGTH OF STAY IN 1b <u>6 HRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Westly</u> First <u>Sexwell</u> Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/81</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Sewell</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>213-42-145</u>	
17. INFORMANT Address <u>—</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cc of Prostate</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/1/1961</u> to <u>3/21/1961</u> , that (I) (we) last saw the deceased alive on <u>2/21/1961</u> and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>P. E. Cox</u>		22b. DATE SIGNED <u>3-27-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>P. E. Cox M.D.</u>		22d. ADDRESS <u>EASTON MD</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Mar. 25, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Roseville Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Roseville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Ashwell</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 29 '61</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





3528

CERTIFICATE OF DEATH

Reg. Dist. No.

03523

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>				c. LENGTH OF STAY IN lb <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTE L. TAYLOR</u>				4. DATE OF DEATH Month Day Year <u>MARCH 10 1961</u>			
5. SEX <u>FEM.</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 1 - 1913</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>ARTHUR J. NASH</u>				14. MOTHER'S MAIDEN NAME <u>HELEN SEYMOUR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>CHESTER MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage (massive)</u> <u>March 10, 1961</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis general cerebral</u> <u>5 years</u>							
(c) <u>hypertensive Cardio-Renal disease</u> <u>4 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malignant hypertension (years)</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 10, 1950</u> to <u>March 10, 1961</u> , that I last saw the deceased alive on <u>March 10, 1961</u> , and that death occurred at <u>9:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmair</u> M.D.				ADDRESS (Street, city or town, state) <u>Stevensville Maryland</u> DATE SIGNED <u>3/4/61</u>			
PHYSICIAN'S NAME (Type) <u>Theodor Sattelmair, M.D.</u>				<u>STEVENSVILLE, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 13</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar R. Lane</u> ADDRESS <u>Church Hill, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 16 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3529

CERTIFICATE OF DEATH

Reg. Dist. No.

03524

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Annie Middle G. Last Tiller				4. DATE OF DEATH Month March Day 25 Year 1961			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1886	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Elliott				14. MOTHER'S MAIDEN NAME Lizzie Mander			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 219-07-6659		INFORMANT Address Sarah Teat, Rural Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Deletation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocardial DUE TO (c) Relief Seeking							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
20e. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 25, 1961 to March 25, 1961 , that I last saw the deceased alive on March 25, 1961 , and that death occurred at 12:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. H. Metcalfe				ADDRESS (Street, city or town, state) Sudlersville, Md.			
PHYSICIAN'S NAME (Type) C. H. Metcalfe				DATE SIGNED 3/27/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 29, 1961		22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		22d. LOCATION (City, town, or county) (State) Crumpton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.				24a. REC'D BY REGISTRAR DATE MAR 30 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "RECEIVED" and "251" are visible at the top.]